Definitions:

**Forced Vital Capacity (FVC):** the volume delivered during an expiration made as forcefully and completely as possible starting from full inspiration.

**Forced Expiratory Volume in the first second (FEV1):** the volume delivered in the first second of an FVC maneuver.

**Obstruction:** flow limitation is observed during spirometry. If the observed FEV1/FVC ratio is down 10 or more from the predicted, obstruction is present.

**Restriction:** Spirometry with low FVC (< 80%) can only suggest restriction. Further testing is needed to confirm.

Acceptability criteria from the American Thoracic Society:

- Good start of test/rapid rise
- Single, clearly defined peak
- Good end of test (6 sec for adults/3 sec for children)
- Free from artifacts (i.e. cough, glottic closure, leaking)

Examples of unacceptable tests:

- Slow start of test
- Rounded peak
- Early termination
- Cough in first second

Repeatability criteria for the American Thoracic Society:

Three (3) acceptable tests must be performed with two (2) tests having FEV1 and FVC within .15L or 150mL of each other.

Coaching patients through spirometry:

Instruct patient to breathe normally. When patient is ready, have him/her take his/her deepest breath and blow as hard as he/she can as long as he/she can. There is a learning curve for spirometry. Use positive reinforcement to build on the patient’s successes. (For example, “That was really good; this time take an even deeper breath.”) Always demonstrate the spirometry maneuver, especially if language is a barrier or communication issues arise.

Appropriate bronchodilator use:

If testing for reversibility, give patient 4 puffs of bronchodilator with a spacer or a standard nebulized dose. Wait 15 minutes after last dose to perform post-bronchodilator maneuver. If a patient cannot perform acceptable baseline maneuvers according to American Thoracic Society criteria or there is no evidence of airflow obstruction, do NOT give a bronchodilator.

Contraindications:

- Recent surgery
- Within one month of a myocardial infarction
- Recent pneumothorax
- Unable to understand directions or inability to seal mouthpiece

CPT codes for spirometry:

94010 spirometry
94060 spirometry with bronchodilator (pre- and post-test)

When using these CPT codes, better reimbursement happens when current symptoms are associated with the appropriate ICD9 code for asthma or COPD.

Refer to a specialist:

- If patient has severe obstruction
- If patient has a restrictive pattern
- If patient does not respond to medications

References:


SPIROMETRY INTERPRETATION

What is the observed ratio (FEV1/FVC) compared to predicted?
Down 10 or greater = airflow obstruction

ATS/ERS* Degree of severity of obstruction based on FEV1

<table>
<thead>
<tr>
<th>Degree of severity</th>
<th>FEV1, % predicted</th>
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</thead>
<tbody>
<tr>
<td>Mild</td>
<td>&gt;70</td>
</tr>
<tr>
<td>Moderate</td>
<td>60-69</td>
</tr>
<tr>
<td>Moderately severe</td>
<td>50-59</td>
</tr>
<tr>
<td>Severe</td>
<td>35-49</td>
</tr>
<tr>
<td>Very severe</td>
<td>&lt;35</td>
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* American Thoracic Society/European Respiratory Society

Is this a good test?
(Acceptability and repeatability criteria on reverse)

Check FVC. If normal (≥80%), restriction can be ruled out. If reduced, further testing is needed to differentiate restriction from obstruction with air-trapping.

What is the observed ratio (FEV1/FVC) compared to predicted?

Down 10 or greater = airflow obstruction

Consistent with asthma diagnosis.
Yes

Consistent with asthma diagnosis.
Yes

Is it reversible? FEV1 ≥ 12% and ≥ 200 mL in youths and adults 12+
≥ 15% and ≥ 200 mL in children < 12

No

• Airflow obstruction that is not significantly reversible does NOT rule out asthma.
• To help differentiate COPD from asthma with airway remodeling/fixed obstruction, further testing options include: DLCO, chest x-ray, and chest CT.

Sample written COPD interpretation:
The FEV1/FVC ratio being down more than 10 from predicted is consistent with airflow obstruction. The FEV1 being 51% of predicted suggests a moderately-severe airflow obstruction (based on the 2005 ATS/ERS guidelines for severity of obstruction). No significant response to albuterol was revealed as the FEV1 only increased 2%. Further testing revealed a diffusion capacity of 50% of predicted. The lateral chest film showed signs of hyperinflation and flattened diaphragm and the chest CT had classic changes seen in emphysema. (Based on the 2007 GOLD guidelines for COPD severity), this 74 year old female with a baseline FEV1 of 51% has Stage II moderate COPD.

Asthma Severity

<table>
<thead>
<tr>
<th>5-11 years</th>
<th>12 + years</th>
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<tbody>
<tr>
<td>Normal FEV1 between exacerbations</td>
<td>Normal FEV1 between exacerbations</td>
</tr>
<tr>
<td>FEV1 &gt; 80% predicted</td>
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</tr>
<tr>
<td>FEV1/FVC &gt; 85%</td>
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Stage I: mild
FEV1/FVC < 70%
FEV1 ≥ 80% predicted
FEV1/FVC normal

Stage II: moderate
FEV1/FVC < 70%
FEV1 50-80% predicted
FEV1/FVC reduced 5%

Stage III: severe
FEV1/FVC < 70%
FEV1 30-50% predicted
FEV1/FVC reduced > 5%

Stage IV: very severe
FEV1/FVC < 70%
FEV1 < 30% predicted or FEV1 < 50% predicted plus chronic respiratory failure

COPD Severity

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Sample written asthma interpretation:
The FEV1/FVC ratio being down more than 10 from predicted is consistent with airflow obstruction. The FEV1 being 77% of predicted suggests a mild airflow obstruction (based on the 2005 ATS/ERS guide for severity of obstruction). The post bronchodilator study reveals a significant response to albuterol with the FEV1 increasing 15% or 550cc. This finding is consistent with diagnosis of asthma although clinical correlation is needed to confirm. (Based on the 2007 NAEPP guidelines for asthma severity), this 28 year old male with a baseline FEV1 of 77% has moderate persistent asthma.

PRE-BRONCH
Observed Predicted % Predicted
FVC (L) 5.25 4.68 92
FEV1 (L) 3.59 4.64 77
FEV1/FVC (%) 68

POST-BRONCH
Observed % Predicted Post % Change
FVC (L) 5.35 94 2
FEV1 (L) 4.14 89 15
FEV1/FVC (%) 77 13

Sample written asthma interpretation:
The FEV1/FVC ratio being down more than 10 from predicted is consistent with airflow obstruction. The FEV1 being 77% of predicted suggests a mild airflow obstruction (based on the 2005 ATS/ERS guide for severity of obstruction). The post bronchodilator study reveals a significant response to albuterol with the FEV1 increasing 15% or 550cc. This finding is consistent with diagnosis of asthma although clinical correlation is needed to confirm. (Based on the 2007 NAEPP guidelines for asthma severity), this 28 year old male with a baseline FEV1 of 77% has moderate persistent asthma.